INDEX OF SURGICAL PROGRESS.

HEAD AND NECK.

I. The "String" Method of Dividing Œsophageal Strictures. By ROBERT ABBE, M.D., New York. The author relates a case of dense, narrow stricture of the œsophagus near its cardiac end, in which, after having opened the œsophagus near the root of the neck and the stomach by the usual gastrotomy incision, he was finally able to pass a very fine conical gum-elastic bougie upward through the stricture; to the end of this bougie he tied a piece of heavy braided silk, and drew it through the canal. By pulling this string back and forth, in see-saw manner, over the distended stricture, these tissues were gradually and rapidly divided, so that enlarging bougies were quickly able to pass with ease until the normal calibre of the œsophagus was restored. After the dilatation he drew a rubber tube the size of one's finger through the stomach up into the œsophagus to a point higher than the stricture and left it in situ, its end projecting through the gastrostomy opening below for some days, while nutrition was maintained by the introduction of food into the stomach through a second tube. No accident marred the progressive recovery of this patient. At the end of a week a second free dilatation under ether and with the aid of the string was done; the largest sized bougie freely enters the stomach; the œsophageal fistula in the neck closed spontaneously in two weeks; the gastric fistula was closed by a plastic operation after eight weeks. He sums up as follows:

The operation for impermeable or very tight stricture is best undertaken as follows: Gastrostomy is done by the oblique incision along the margin of the costal cartilages. Digital examination of the œsophageal orifice is made and a small, conical, gum-elastic bougie guided into it by the finger. If dilatation is easy, larger bougies are to be used, but if resistance is great force is dangerous. The smallest bougie is then to be made to carry a heavy braided ligature silk from the stomach to the mouth. A larger bougie is now passed from the stomach alongside the string and pressed tightly into the stricture, so as to stretch it. The string is now drawn upward by the fingers introduced well back in the mouth, and the bougie will be felt to advance at once as the string wears away the tense stricture. Larger bougies are now pressed in and the string see-sawed back and forth. When the largest size has been attained a corresponding rubber tube is drawn up the œsophagus past the point of stricture, its lower end remaining outside the stomach wound. A smaller tube is introduced into the stomach for nourishment. The patient can thus drink water for refreshing the mouth, or swallow saliva without contaminating the wounded surface, which the tube also serves to keep dilated. The large tube may be removed the second or third day, and dilating bougies introduced from the mouth after the fourth day. The gastrostomy wound may be closed by a plastic operation whenever the patient has gained strength.—*Medical Record*, February 25, 1893.

II. The Closure of Cut Throat and Surgical Wounds of the Air Passage by Immediate Suture. By HENRY MORRIS, M.B., LOND. (London). The author departs from the approved methods of leaving cut throat wounds to heal by granulation and cicatrization, and seeks by the liberal employment of buried and superficial aseptic sutures to bring about immediate union. He takes great care, after thoroughly cleansing all the parts about the wound, to unite accurately, end to end, the cut edges of each structure which has been divided—cartilage with cartilage, membrane with membrane, muscle with muscle, fascia with fascia and skin with skin. He also inserts a few pieces of drainage tube at selected points of the wound, and by these means provides against the sources of danger ordinarily attributed to immediate suture, such as suffocation from recurrent hæmorrhage or purulent discharges into the air passages, inflammation and œdema of the neighboring parts, dyspnœa from the collection of